

the adhesion-cutting to a nicety. We have had considerable difficulty with this procedure to date and, while the procedure appears simple, the complications may be very grave. On the other hand, we have used the paraffin fill on a group of cases, and are still using it in selected ones and so far have no reason to regret our choice.

From a surgical viewpoint I believe there are two exceptionally difficult groups of cases to obtain satisfactory collapse. First, the enormous apical thick-walled cavity, and secondly, the patient with an existing secondary bronchiectasis of the right middle or lower lobe. A bronchial stenosis may or may not be present. If present it is almost, if not entirely, impossible to rid the patient of all sputum by means of a thoracoplasty. In this suspected group bronchoscopy may prove of diagnostic value and also the guarded use of brominol. Bronchoscopy should not be used without due thought and consideration, as it is by no means an entirely innocent procedure when dealing with active pulmonary tuberculosis. However, it is of great value in the above group of cases, for if the bronchiectatic portion of lung can be proved to be free from tubercle bacilli, as is sometimes the case, lobectomy may be considered.

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ESTHER ROSENCRANTZ, M. D. (San Francisco Hospital San Francisco).—I agree with the statement that a larger percentage of tuberculous patients than those now receiving surgical treatment would probably benefit by one of the procedures described. To enable these patients to profit by these measures of relief there should be a closer coöperation than now exists between surgeons and physicians. Especially is this the case in those patients with chronic ulcerative tuberculosis, who stay year after year in tuberculosis hospitals, whose condition has improved to such an extent that there is no fever whatsoever, and who are apparently well except for the occasional cough and persistent positive sputum.

The tendency is to consider these patients incurable and suitable for routine medical treatment only. If, however, one considers how often the pathologic condition in the lung changes over a long period of time when the patient is improving, and how patients who on admission were bilateral, eventually fibrose on one side, while the other side remains active, and if one studies these patients from the standpoint of possible surgical intervention, I think that the number of patients who might be treated by one of the methods described in this paper would be found to be considerably higher.

There the responsibility rests with the physician since it is he who has constant access to the patient, and it is he who follows the course of the disease from the time the patient first comes for treatment.

## THE LOCAL TREATMENT OF ECZEMA IN INFANCY AND CHILDHOOD\*

By HIRAM E. MILLER, M. D.  
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DISCUSSION by Samuel Ayres, Jr., M. D., Los Angeles; Albert H. Rowe, M. D., Oakland; Clifford Sweet, M. D., Oakland.

THIS paper will consider briefly the local treatment of eczema in infancy and childhood from the dermatological standpoint. I do not believe that local treatment alone will cure most children with eczema. It must be combined with

dietary, allergic and other procedures. Neither do I believe that internal treatment alone will cure all of them. It must be used in conjunction with rational local therapy. The best results are obtained when pediatrician and dermatologist work together. Practically, however, a pediatrician with some dermatological training, or a dermatologist with a knowledge of pediatrics, can generally obtain satisfactory results.

Internal treatment is governed by a knowledge of the underlying cause in the individual case. Local treatment requires a knowledge of the reaction of different types of inflamed skins to various remedies. Some of this information can be obtained from textbooks, but most of it will come only with experience.

The choice of the remedy depends upon the type of the eruption, its severity, its location and extent, as well as climatic conditions. Each individual skin has certain idiosyncrasies as to drugs, as well as to types of medication. Some skins will not tolerate ointments, no matter what they contain; others may become irritated when lotions are applied.

Local medication should be mild at first, and should not be frequently changed in stubborn cases. A small number of remedies carefully handled will cure most patients. Certain remedies will give brilliant results with one physician, and yet always irritate in other equally skilled hands. It is best, therefore, to use only the remedies with which one is thoroughly familiar.

### GENERAL CARE

In the treatment of any type of eczema, there are certain underlying principles that must be followed. All sources of local irritation should be removed before topical applications are considered. The child must be kept out of the sun, wind and overheated rooms. Ideally, during the winter months, the child's room should be heated and the windows kept open. The clothing should not be coarse nor irritating, and the child must not be dressed nor covered too warmly. Soap and water should not be used on eczematized areas. Olive oil or some similar bland oil may be used for cleansing purposes.

Diapers should be changed as soon as possible after being soiled. They must be carefully washed with a mild soap and thoroughly rinsed. Rubber pants should never be worn over the diapers by a child with an eczematous tendency.

Hospitalization is desirable, and necessary for many infants with extensive eczema. It often hastens recovery, and permits the carrying out of mechanical adjuncts to therapy. It also separates the child from distracted parents, and allows them to obtain some rest. It frequently changes an irritable and ungovernable child into a composed and happy one.

### CLASSIFICATION

For descriptive purposes, as indicated in Table 1, there are four general types of eczema occurring in infancy and childhood:

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\* Read before the Pediatrics Section of the California Medical Association at the sixty-second annual session, Del Monte, April 24-27, 1933.

TABLE 1.—*Types of Eczema of Infancy and Childhood*

- |                    |                        |
|--------------------|------------------------|
| 1. Overweight type | 3. Intertrigenous type |
| 2. Seborrhic type  | 4. Impetiginized type  |

Occasionally, the eruption in a child may be distinctly of one type. Generally, however, two or more types of the disease will be present at the same time, or during the course of the disease. This classification, however, will facilitate the discussion of therapy.

## LOCAL THERAPY

The successful treatment of eczema is difficult without a knowledge of the use of crude coal tar. Table 2 explains its use:

TABLE 2.—*On the Uses of Crude Coal Tar*

- Bi-product in the manufacture of coal gas
1. Applied undiluted to localized areas of eczema at three-day intervals.
  2. Used in a paste or ointment, never under a bandage. To be removed daily with olive oil.
- |                          |      |                          |      |
|--------------------------|------|--------------------------|------|
| 1. R Crude coal tar      | 3- 2 | 2. R Crude coal tar      | 3- 2 |
| Zinc oxid aa             |      | Zinc oxid aa             |      |
| M. and add               |      | M. and add               |      |
| Corn starch              | 15   | Petrolatum q. s. a. d    | 30   |
| Petrolatum q. s. a. d    | 30   | M. sig. locally b. i. d. |      |
| M. sig. locally b. i. d. |      | to dry areas             |      |
3. R Crude coal tar
 .3 2 |
  - Zinc oxid aa
  |
  - M. and add
  |
  - Paste Lassar q. s. a. d
 30 |
  - (no acid)
  |
  - M. sig. locally b. i. d.
  |

Formula 3 has given the most satisfactory results in my hands.

The treatment of the various types of eczema is shown in Tables 3, 4, 5 and 6:

TABLE 3.—*Treatment of Overweight Type of Infantile Eczema*

Feeding of most importance in this type.  
Local applications must be soothing.  
Lassar's paste under mask; splints to arms.  
Calamine lotion or calamine cream.  
Ultra-violet light; occasionally x-ray therapy.  
Crude coal tar preparations.  
5 to 10 per cent naftalan in Lassar's paste (without acid).

TABLE 4.—*Treatment of Seborrhic Type of Infantile Eczema*

*Scalp:* Remove crusts with olive oil.

R Resorcin	3-1.2	1-3% sulphur,
Glycerin q. s.		ammoniate of mercury
Petrolatum q. s.	30	or yellow oxid of
M. sig. locally to scalp after		mercury may be used
removing crusts		

*Body:* Care in cleansing skin; apply soothing lotions or pastes: 2% crude coal tar; 10% naftalan or 1-2% ammoniate or yellow oxid of mercury, all put in Lassar's paste (without acid).

TABLE 5.—*Treatment of Intertrigenous Type of Infantile Eczema*

1. Exclude lues and monilia infections.
  2. Cleanse with oil; wash diapers thoroughly; do not use rubber pants; keep areas dry.
  3. Dusting powders, lotions or pastes superior to grease.
- Stearate of zinc. Equal parts of boric acid and talc. May add 25 per cent calamine, 25 per cent zinc oxid and ½ to 1 per cent camphor.
- Lotio nigra and aq. calcis, equal parts. Calamine lotion. Lassar's paste, etc., are of value.

TABLE 6.—*Treatment of Impetiginized Type of Infantile Eczema*

1. Removal of crusts with boric acid compresses.
2. Application of 1 per cent ammoniate or yellow oxid of mercury in Lassar's paste (no acid).
3. Coryza, otitis, scabies, pediculosis capitis may be the underlying cause.

## COMMENT

The successful treatment of eczema in infancy and childhood demands considerable attention to details. It requires more than the mere application of a grease. The long duration of the disease, as well as the probability of recurrences, should be explained to the parents early in the course of treatment. Fortunate indeed is the practitioner who is called to treat these children late in the course of their disease.

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## DISCUSSION

SAMUEL AYRES, JR., M. D. (2007 Wilshire Boulevard, Los Angeles).—I am in complete agreement with Doctor Miller's views regarding the importance of crude coal-tar in the treatment of these cases. To secure the best results, the physician should confer with his favorite pharmacist regarding the details of compounding this remedy and, having satisfied himself that the druggist is able to prepare a satisfactory ointment, he should instruct his patients to have the prescriptions filled at that place. As Doctor Miller has indicated, the coal-tar and zinc oxid should be mixed separately; then the cornstarch and the petrolatum separately, and then these two mixtures combined. This should result in a smooth, coal-black paste. If the color is gray, green, or brown, you can be certain that it was not made properly and that it is very likely to irritate.

I do not agree with Doctor Miller in insisting that the tar ointment should not be covered with a bandage. On the contrary, I insist that it should be bandaged. This accomplishes several things: it insures that the areas are kept covered with the ointment, it prevents scratching, it prevents soiling of the linen, etc., and it insures against exposure to sunlight, which would be most irritating since coal-tar exerts a photosensitizing effect on the skin. I have never observed any deleterious effects from covering the parts to which the ointment has been applied.

However, if coal-tar is used for more than two or three weeks continuously, a pyogenic folliculitis occasionally develops, which usually clears promptly on changing to a weak ammoniated mercury ointment. Coal-tar ointment is contraindicated in the presence of follicular infections, but it is extremely efficacious not only in the ordinary allergic eczemas, but also in eczematoid eruptions due to yeasts or fungi, or to bacteria, as in cases of infectious eczematoid dermatitis.

Dermatology and pediatrics are greatly indebted to Dr. Charles J. White of Boston, who introduced crude coal-tar therapy in eczema.

One other type of eczema which has not been mentioned is a more or less generalized oozing or exfoliative, due to arsenic. I have seen two such cases in small babies, in whom arsenic in abnormal amounts was found in the urine and which cleared up under the oral administration of sodium thiosulphate, with a bland external application such as cocoa butter or plain Lassar's paste. The source of arsenic in both cases was probably in the form of medication which the mother was taking during pregnancy.

With Doctor Miller, I would emphasize again that local treatment alone is quite inadequate in the successful management of most cases of infantile eczema.

ALBERT H. ROWE, M. D. (242 Moss Avenue, Oakland).—Eczema in infancy and childhood is usually due to food allergy, though inhalant and contact sensitizations are of importance, especially in older children. To aid in the determination of the allergic etiology, skin tests with all foods eaten, and with important inhalant and contact allergens to which the child may be exposed, are indicated. The skin-sensitizing bodies to the causative allergens may not be present, though children are more apt to react than are adolescents or adults. Because of this fallibility of the skin reaction, trial diets and test environmental control may be necessary to help in the discovery of the fundamental allergies. The necessity of such trial diets has been emphasized by Blackfan and Schloss, and more recently by Hill and Cohen. Hill's article on "Eczema in Infancy" in the *Journal of Pediatrics* not only describes local therapy detailed by Doctor Miller, but discusses diets based on positive and negative skin reactions. For the milk-sensitive child, Sobee, as described by Hill, and more recently Cemac, recommended by Cohen, are of definite value. The child who gives positive reactions to animal emanations, miscellaneous substances, dusts, and possibly pollens, with or without reactions to foods, necessitates attention to diet, environment and contacts if control of eczema is attained. Local therapy, as described by Doctor Miller, must be used with practically all patients, whether or not allergic control is carried out. With the elimination of the allergenic factors, the eczematous lesions require much time to disappear and are hastened by dermatologic procedures, so tersely described in this paper by Doctor Miller.

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CLIFFORD SWEET, M. D. (242 Moss Avenue, Oakland). I agree whole-heartedly with Doctor Miller's point of view. The child who has eczema must be studied thoroughly and treated carefully with all the means at our command.

Since hearing his paper last April, I have used crude coal-tar more than I had formerly, and have found it very useful. All diapers should be boiled daily, as well as thoroughly washed and rinsed. For the impetiginized lesions it is often necessary to use a stronger ammoniated mercury than the one per cent ointment. After making certain that the patient's skin is not hypersensitive to ammoniated mercury, a stronger ointment may be prescribed. In severe cases it is often necessary to remove the crusts oneself or have it done by another experienced person; few mothers will do it thoroughly.

In addition to all other attention to detail, much effort must be expended in carefully explaining to the parents, not once but many times, the problem to be solved. I emphasize what Doctor Miller has said, and add in brief the explanation which I have found comforting to perplexed and worried parents:

1. Eczema is not a disease.
2. Eczema is not contagious.
3. Eczema is not evidence of tainted blood, and no family has aught to be ashamed of because some member has it.
4. Eczema is evidence that the individual reacts too readily to foreign proteins. This reaction to proteins is universal in all human beings, varying only in the degree of its severity.
5. Proteins are present in all living structures, and therefore the offending protein may not be contained in the food substances which are our chief source of protein food.
6. The child with eczema is in every way a normal, healthy human being to whom we will give our best efforts in order to assist him over his present time of very real and distressing difficulty. Fortunately, in the vast majority of babies with eczema the acute hypersensitivity diminishes after the first several months, and the body learns to live more successfully with its varied protein intake and contacts; just as by experience and education the child learns to become a successful member of a varied and often irritating human society.

## FRACTURES AT THE LOWER END OF THE RADIUS—THE ROLLING-PIN METHOD FOR THEIR REDUCTION\*

By WILLIAM ARTHUR CLARK, M. D.  
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DISCUSSION by John Dunlop, M. D., Pasadena; William F. Holcomb, M. D., Oakland; Frank A. Lowe, M. D., San Francisco.

FOLLOWING fractures near the wrist, accurate apposition of the fragments is necessary for function as well as appearance. Slight offset or angulation in the radius or ulna at this site will result in noticeable deformity which would not be apparent in regions where the bones are more thickly covered with soft tissues. Also, function may not be restored 100 per cent unless anatomic reduction is accomplished. The ugliest and most crippling deformity is caused by radial deviation and anterior displacement of the distal fragment. The classical Colles's fracture may also result in slipping or settling of the distal fragment toward the radial side, and perhaps also posteriorly, carrying the wrist and hand with it. This may occur even two or three weeks after reduction, especially if the ulna styloid has been broken, thereby loosening the anchorage of the carpus to the ulna, or if the patient is elderly and union slow with some absorption in the fragments. It may occur also as a result of imperfect reduction. If the distal fragment is left with a very slight offset or slight tilt, there is a tendency for the slight deformity to become a bad deformity, due to the constant pull of the overlying tendons.

### REDUCTION METHODS

Primary reduction to anatomic position, followed by careful splinting, should preclude these difficulties. Indirect methods of applying force to the short distal fragments are frequently ineffective, resulting perhaps in partial reduction, but leaving more or less offset in apposition. Extension on the hand with countertraction on the forearm gives a force which is expended mostly on the tendons, very little being applied to the bone fragments. Flexion, pronation, and adduction of the wrist, though sometimes necessary, are usually not sufficient for complete restoration of normal position. Most surgeons have abandoned these indirect, indefinite manipulations for the direct application of force to the bone fragments. Scudder, Roberts and Kelley, and the textbooks of others describe methods of reducing Colles's fracture by pressure with the operator's thumbs on the distal fragment, accompanied by manipulation and traction.

### ROLLING-PIN METHOD

When pressure with the thumbs fails, something harder with which to push against the distal fragment is necessary. After experimenting with various sizes and shapes in wood, I found that the most serviceable thing to use in reducing these

\* Read before the General Surgery Section of the California Medical Association at the sixty-second annual session, Del Monte, April 24-27, 1933.